OMB Number: 2900-0219
Est. burden: 10 minutes

Department of Veterans Affairs

CHAMPVA Claim Form

VA Health Administration Center CHAMPVA PO Box 65024 Denver CO 80206-9024 1.800.733.8387

Attention: After reviewing the following, complete form in its entirety (print or typewritten only) and return with required documentation. Limit entries to one character per block and do NOT exceed the designated space (i.e. do NOT extend last name into First Name area).

Claim form usage: This form is to be completed by the patient, sponsor, or guardian and is mandatory for all beneficiary claims. This claim form is NOT to be used for provider submitted claims.

Other health insurance (OHI): If OHI exists, attach OHI's Explanation of Benefits (EOB) to the provider's itemized billing statement(s). Dates of service and provider charges on EOB must match billing statements.

Timely filing requirement: Claims must be received no later than one year after the date of service or, in the case of inpatient care, within one year of the discharge date.

Itemized billing statements: An itemized statement must be attached and contain:
- patient name, date of birth, and CHAMPVA Authorization Card (A-Card) number (same as patient's Social Security Number);
- provider name, degree, tax identification number (TIN), address and telephone number; and
- service dates, itemized charges and appropriate procedure/diagnosis codes for each service (i.e. CPT-4, HCPCS, and ICD-9-CM codes), including narrative descriptions. Pharmacy claims are to include name, quantity, strength, and NDC of each drug.

Section I - Patient Information

Last Name | First Name | MI | Social Security Number

Street Address ☐ check if new | Date of Birth (mm/dd/yyyy)

City | State | Zip Code | Telephone Number (include area code)

Section II - Other Health Insurance (OHI) Information

By law, other coverage must be reported. Except for CHAMPVA supplemental policies, CHAMPVA is always the secondary payer.
If more space is needed, please continue in the same format on a separate sheet.

- Was treatment for a work-related injury or condition? ☐ yes ☐ no
- Was treatment for an injury or accident outside of work? ☐ yes ☐ no
- Is patient covered by other primary health insurance to include coverage through a family member (supplemental or secondary insurance excluded)?

☐ yes (check type below and provide coverage information on the right)
- ☐ employer sponsored (group)
- ☐ private (non-group)
- ☐ Medicare (Part A or B)
- ☐ other (specify) _____

☐ no (proceed to Section III)

Name of Other Health Insurance (OHI)

OHI Policy Number | OHI Telephone Number (include area code)

Name of Other Health Insurance (OHI)

OHI Policy Number | OHI Telephone Number (include area code)

Section III - Sponsor Information

Last Name | First Name | MI | Social Security Number

Section IV - Claimant Certification

Federal Laws (18 USC 287 and 1001) provide for criminal penalties for knowingly submitting or making false, fictitious, or fraudulent statements or claims.

Release of Medical Information: Signature in this section authorizes the patient's providers to release medical record documentation related to the services associated with this claim. This consent pertains to all medical records, including records related to treatment for psychological and psychiatric conditions, drug and alcohol abuse, acquired immune deficiency syndrome, human immunodeficiency virus infection, and sickle cell disease.

➔ ***I certify that the above information and attachments are correct and represent actual services, dates, and fees charged. (Sign and date on right.) If certification is signed by a person other than the patient, complete the information the signature and date.***

Signature ✗ | Date

Last Name | First Name | MI | Relationship to Patient

Street Address

City | State | Zip Code | Telephone Number (include area code)

(retain this portion for your records)

CHAMPVA Claim Form **Appendix**

Privacy Act: All information collected is subject to the provisions of the Privacy Act under 5 USC 522a. **Authority:** This information is solicited under 38 USC 501 and 1713; 10 USC 1079 and 1086. **Disclosure:** Disclosure is voluntary, but failure to provide the information may result in delay and/or denial of future CHAMPVA benefit claims. Failure to furnish this information will have no adverse impact on any other VA benefits to which the patient may be entitled.

Paperwork Reduction Act: This information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. The purpose of this data collection is to provide a mechanism to claim CHAMPVA benefits.

VA Form
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